UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CHARLES BURKE and REBECCA BURKE 16142 Draco Road Stewartstown, PA 17365 Plaintiffs v. HEALTH INSURANCE INNOVATIONS 218 E. Bearss Avenue Tampa, FL 33613 and COORDINATED BENEFIT PLANS, LLC 18167 US Highway 19 N Ste 450 Clearwater, FL 33764-6574 and STARR INDEMNITY AND LIABILITY COMPANY 399 Park Avenue 8th Floor New York, NY 10022 Defendants	Civil Action No. 1:13-CV-02810 Judge John E. Jones III Complaint Filed 11/18/2013 Jury Trial Demanded

PLAINTIFFS' FIRST AMENDED COMPLAINT

Plaintiffs, by and through their attorneys, Katherman, Briggs & Greenberg, LLP, hereby file the instant Complaint setting forth the following causes of action:

INTRODUCTION

1. This action seeks compensatory relief to redress the damages Plaintiff sustained as a result of Defendants' breach of contract, negligence and/or bad faith.

PARTIES AND JURISDICTION

2. Jurisdiction is based upon the diversity of citizenship between the parties.

3. Plaintiffs, Charles and Rebecca Burke, who are husband and wife, are adult individuals and are both citizens of the Commonwealth of Pennsylvania.

4. Defendant, Health Insurance Innovations, (hereinafter "HII") is a corporation with a principle place of business in Florida which transacts business in the Commonwealth of Pennsylvania and specifically within the jurisdiction of this Court.

5. Defendant, Coordinated Benefit Plans, LLC, (hereinafter "CBP") is a business with a principle place of business in Florida which transacts business in the Commonwealth of Pennsylvania and specifically within the jurisdiction of this Court. CBP's documentation indicates it "is a nationally licensed full service Third Party Administrator" and, according to its website, "maintains a long and distinguished history of competence and professionalism in servicing agents, policyholders and their insurers." CBP acted as a third party administrator

handling claims submitted by Plaintiffs under a policy of short term medical insurance issued by Starr.

6. Defendant, Starr Indemnity and Liability Company, (hereinafter "Starr") is a corporation with a principle place of business in New York which transacts business in the Commonwealth of Pennsylvania and specifically within the jurisdiction of this Court.

7. The amount in controversy, without interest and costs, exceeds the sum or value specified by 28 U.S.C. §1332 and 28 U.S.C. §1332(c)(1).

VENUE

8. All actions complained of herein occurred within the jurisdiction of this Court and involved the defendants who reside in and/or have a principle place of business within the Court's jurisdictional limits.

9. Venue is invoked pursuant to 28 U.S.C. §1391(c).

STATEMENT OF FACTS

10. On or about January 11, 2011, Plaintiffs called HII to purchase a short-term health insurance plan.

11. HII advertises online via www.hiiquote.com that HII has "long-standing relationships with best-in-class carriers [that] enable[s] us to provide quality, niche insurance products, including, but not limited to: Short-Term Medical Insurance...."

12. On or about January 11, 2011, Mr. and Mrs. Burke spoke with Benjamin Barson, a licensed sales agent with HII who asked the Burkes general health questions and searched multiple insurance carriers for short term medical health insurance for the Burkes.

13. In the course of their discussion, Mr. Barson asked the Burkes to divulge to him the medications they currently took because one of the insurance applications he was considering asked for such information. In addition to medication taken by his wife and daughter, Mr. Burke specifically told Mr. Barson that he took oxycodone for arthritis in his neck. Based on the medications told to him, Mr. Barson told the Burkes that they would not qualify for the particular plan he was looking at. Mr. Barson then looked for and found the short-term medical plan from Defendant Starr that is the subject of this case. Mr. Barson specifically told Mr. Burke that he would qualify for the Starr plan and he transferred Mr. Burke to a different person to answer a series of questions.

14. During this process, Mr. Burke did not have any application documents available to him to read himself.

15. The questions posed by the next representative included the following:

> Q5: Within the past 5 years, have you or any person to be insured been aware or, diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart

> attack, had heart surgery, COPD (Chronic Obstructive Pulmonary Disease) or emphysema, kidney disorder or disease, liver disorder or disease, neurological disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee or him, diabetes (not applicable to DC residents), alcohol abuse or chemical dependency, or does anyone listed on the application currently weigh over 250 pounds (women) or over 300 pounds (men)?

16. Mr. Burke initially had no recollection of even having been asked this question until Defendants produced an audio recording of the call. The question is overly-long and confusing and contains multiple terms of which Mr. Burke did not fully understand. These terms include but are not limited to, "degenerative disc disease or herniation/bulge" and "degenerative joint disease." He was not asked if he had arthritis in his neck nor was he asked if he ever tore a meniscus in his knee. Mr. Burke answered the questions to the best of his ability and relied upon the assurances of Mr. Barson that he would qualify for the Starr plan.

17. On or about January 11, 2011, upon information and belief, Mr. Barson then completed and submitted an application for health insurance coverage for the Starr plan on behalf of Mr. Burke.

18. Unbeknownst to Mr. Burke, he was also enrolled as a member in the Med-Sense Guarantee Association, which purports to exist for non-profit educational purposes but, upon information and belief, appears to exist only for the purpose of selling short-term medical plans.

19. On or about January 12, 2011, Mr. Burke's application was approved and he became an insured under a short-term medical insurance policy number STS6412400 issued by Starr.

20. Thereafter, Mr. Burke underwent medical care and treatment.

21. Bills for this care and treatment were submitted to CBP for processing as the third-party administrator for Starr.

22. On or about March 23, 2011, Mr. Burke was diagnosed with kidney cancer.

23. Thereafter, Mr. Burke underwent medical care and treatment for kidney cancer, including the removal of one of his kidneys.

24. CBP/Starr required pre-approval for Mr. Burke's cancer-related medical treatment and repeatedly granted said pre-approval.

25. CBP/Starr flagged Mr. Burke's bills solely due to the high dollar amount at issue and, on that basis alone, initiated an investigation on or about June 6, 2011 designed to produce a basis upon which it could deny said bills by rescinding the policy it had just accepted and issued a few months before.

26. On or about June 6, 2011, CBP/Starr sent correspondence to Mr. Burke requesting that he identify all physicians he saw from January 12, 2006 to the date of the letter. The letter states that the purpose for requesting such information is "in order for us to process your claim accordingly." It does not state

the truth, that CBP/Starr planned to avoid paying an expensive claim by searching for any reason, even one completely unrelated to Mr. Burke's cancer diagnosis, upon which to rescind the policy. Mr. Burke provided CBP/Starr with the requested information.

27. On or about August 31, 2011, CBP/Starr sent to Mr. Burke an authorization for his signature permitting his physicians to release his confidential medical records. The letter states that the purpose for said authorization is "[i]n order to continue process of your claim(s)," because "additional information is required from your medical providers." Again, the letter does not state its real objective, that being to continue to search for a basis upon which to rescind the policy. Mr. Burke, thinking that CBP/Starr needed this authorization to pay his claims, signed and returned it. Said authorization stated that it would remain effective for 24 months from the date of its signing.

28. On or about September 22, 2011, CBP received Mr. Burke's prior records from his primary care physician and noted in its file, ". . . nothing regarding mass was during the lookback period." CBP continued to search Mr. Burke's history to find a basis on which to rescind his policy.

29. On or about October 17, 2011, CBP received Mr. Burke's prior records from Hershey Medical Center and subsequently noted in its file "No history in these records to indicate tumor/kidney cancer prior to eff date of

coverage." CBP continued to search Mr. Burke's history to find a basis on which to rescind his policy.

30. On or about January 26, 2012, approximately six months after CBP initiated its investigation, Mr. Burke called CBP to inquire as to the status of the acquisition and review of his medical records and when he could expect his medical bills to be paid. He was told there was no new information to provide to him.

31. On or about February 6, 2012, Mr. Burke called CBP again to inquire as to the status of the acquisition and review of his medical records and when he could expect his medical bills to be paid. He was told that his signature was required on another authorization.

31. On or about February 15, 2012, approximately five and half months after Mr. Burke signed an authorization to permit the release of his confidential medical records, CBP/Starr sent another such authorization to him to sign.

32. On or about March 6, 2012, Mr. Burke called CBP again to inquire as to the status of the acquisition and review of his medical records and when he could expect his medical bills to be paid. The CBP operator identified as Naomi Jones noted that she, "sent diary to expedite this claim, it appears that all the medical records are here and accounted for."

33. On or about April 9, 2012, Mr. Burke called CBP again to inquire as to the status of the acquisition and review of his medical records and when he could expect his medical bills to be paid. The CBP operator identified as Moises Reyes noted that he told Mr. Burke that the investigation was completed on April 4, 2012 and he advised Mr. Burke to allow more time for claims to be processed. Mr. Burke understood this to mean that now, more than a year after his cancer diagnosis, his claims were finally going to be paid.

34. On or about April 30, 2012, Mr. Burke again called CBP to inquire as to why his bills had not yet been paid. This time he was told by the CBP operator identified as Jessica Turbin that they now needed records from a Dr. Black. She said there was confusion over Dr. Black's status with Hershey Medical Center and that she would look into that and call him back. Upon information and belief, neither Jessica Turbin nor anyone else at CBP ever called him back.

35. On or about May 4, 2012, Mr. Burke again called CBP to let them know that he was not called back. The CBP operator identified as Lillian Montanez Asberry told him that it appeared that the medical records were received.

36. On or about May 8, 2012, Mr. Burke again called CBP to inquire as to why his bills had not yet been paid. The CBP operator identified as Kenneth Febles noted that he told Mr. Burke that they are still reviewing his file but they will call him back "as soon as we get something."

37. On or about May 16, 2012, CBP operator Jessica Turbin called Mr. Burke and noted that she advised him that his claims, "are starting to be paid but in high dollar review." Mr. Burke interpreted this to mean that his bills were finally being paid.

38. On or about June 26, 2012, more than a year after CBP/Starr initiated its review, it sent a series of letters to several of Mr. Burke's providers seeking prior records and sent to Mr. Burke yet another letter asking him to identify his medical providers from January 12, 2006 to the date of the letter despite his having provided this exact information to CBP/Starr approximately a year prior.

39. On or about August 2, 2012, CBP's internal claims note that it reviewed records it received from York Hospital which contained no reference to cancer prior to the effective date of Mr. Burke's policy. The reviewer, identified as "RWL," notes on that date, "I feel at this time once we receive the PCP info back, we can move forward with processing for payment." By this date, it is approximately one year and two months since CBP/Starr initiated its investigation.

40. On or about August 7, 2012, Mr. Burke again called CBP to inquire as to why his bills had not yet been paid. The CBP operator identified as Carmen Martinez-Castro noted, "looks like we have everything on file," and that she advised Mr. Burke that she was "going to send the file to a claim examiner today to

reprocess." Mr. Burke interpreted this to mean that his bills were finally being paid.

41. On or about September 24, 2012, Mr. Burke again called CBP to ask if any bills had yet been paid. The CBP operator identified as Reinaldo Cabrera noted that he advised Mr. Burke that his claims were under a high dollar review and that he would call him back after he found out more information. Neither Mr. Cabrera nor anyone else at CBP ever called Mr. Burke back.

42. On or about October 10, 2012, Mr. Burke again called CBP to inquire as to the status of his claims. The CBP operator identified as Moises Reyes noted that he advised Mr. Burke that the claims were not yet approved because they needed additional office notes. Thus, 14 months after CBP/Starr initiated its investigation by which it merely needed to acquire Mr. Burke's medical records and review them, it was now informing him that his claims were still not processed because it didn't have all the records it needed.

43. On or about December 14, 2012, Mr. Burke again called CBP to inquire as to the status of his claims. He noted his frustration with the process and the fact that bills were still not paid and told the CBP operator identified as Deidre Eller that this would be the last time he called to inquire before he contacted an attorney because he was being sued by his medical providers for $80,000. Eller's

notes state that the file had gone to management for review as of November 20, 2012 and asked Mr. Burke to please allow more time.

44. On or about January 11, 2013, Mr. Burke again called CBP to inquire as to the status of his claims. Mr. Burke told the CBP operator identified as George Vincent that all of his accounts had been sent to collections due to these unpaid bills and that he is upset that this process has gone on for so long. Mr. Vincent gave Mr. Burke the name of his supervisor so he can call her directly.

45. On or about February 1, 2013, Mr. Burke called CBP again and spoke again with George Vincent and told him the supervisor, Tracy Wallace, had failed or refused to return his calls. Mr. Burke said he was filing a complaint with her supervisor.

46. On or about February 5, 2013, Mr. Burke called CBP again and spoke with a CBP operator identified as Reinaldo Cabrera. Cabrera noted that it, " Looks like it was forwarded for completion but nothing done."

47. On or about the following day, February 6, 2013, CBP mailed to Mr. Burke informing him that Starr elected to rescind his policy on the claimed basis that a question on his enrollment application was answered incorrectly. As such, it was refunding his premiums less any claims payments made.

48. Starr's rescission of the policy was not based on any pre-existing condition related to cancer because Mr. Burke had no such pre-existing conditions.

49. Starr's decision to rescind Mr. Burke's policy nearly two years after his cancer diagnosis was based on the notion that he committed a material misrepresentation when he responded negatively to Question 5 during the application verification process. Starr asserts that Mr. Burke's history of arthritis in his neck and an ACL tear in his knee constitute a valid basis on which to rescind his policy of health insurance.

50. Mr. Burke did not commit a material misrepresentation in his application. Defendants never verified whether Mr. Burke properly understood the terms "degenerative disc disease or herniation/bulge" and "degenerative joint disease" during the application process. He was not asked if he had arthritis in his neck nor was he asked if he ever tore a meniscus in his knee. Defendants never investigated or verified Mr. Burke's conversation with Mr. Barson during the application process during which time Mr. Burke divulged the medications he takes specifically for arthritis in his neck.

51. Defendants gave pre-approval for all of Mr. Burke's cancer related treatments for which such approval was required and led to him to believe both on those occasions and during multiple subsequent telephone conversations that his bills would be paid.

52. Defendants undertook an investigation designed to determine a basis on which to rescind Mr. Burke's policy and thereby avoid paying his "High

Dollar" medical bills and thereafter took approximately 20 months to complete the relatively simple operation of acquiring his medical records and reviewing them.

53. Mr. Burke was forced to call Defendants on no less than 24 separate occasions to inquire as to the status of his claims. He spoke to no less than 14 different CBP operators during those phone calls. He was told on no less than three occasions that his bills were being paid. He told Defendants that his accounts with his providers were in collections and that he would be sued by his providers. Then, Defendants elected to rescind his policy and not pay his bills for reasons having nothing to do Mr. Burke's cancer diagnosis or treatment.

54. Based upon information and belief, the Defendants knew or should have known that the procedures and processes that were in place for the application and/or investigative process were inappropriately incentivized and/or inadequate for ensuring complete and accurate information was obtained.

55. Based upon information and belief, the Defendants knew or should have known that the applicants relied upon the Defendants' employees or actual or ostensible agents to perform a reasonable and necessary investigation in a timely manner.

COUNT I

BREACH OF CONTRACT

56. Paragraphs 1 through 55 are incorporated herein.

57. The Defendants failed to make payments under the insurance policy as required in an amount in excess of $121,842.02.

58. Plaintiffs have incurred costs since the Defendants' breach of contract, which costs would have been covered by the insurance contract absent the Defendants' breach.

59. Plaintiffs will continue to incur expenses for health insurance in the future, which costs would have been covered by the insurance contract absent the Defendants' breach.

60. Plaintiffs have endured considerable economic and emotional distress as a direct result of the Defendants' conduct.

WHEREFORE, Plaintiffs demands judgment against the Defendants in an amount in excess of this Court's jurisdictional limitations plus costs and interest.

COUNT II

INSURANCE BAD FAITH

61. Paragraphs 1 through 60 are incorporated herein.

62. Defendants failed to pay claims under the policy and unreasonably rescinded the insurance policy.

63. Defendants' conduct constitutes insurance bad faith in violation of 42 Pa.C.S. §8371.

64. Defendants' conduct constitutes bad faith under applicable common law.

65. Defendants' conduct was willful, wanton, and reckless and was conducted with disregard for the rights of Plaintiffs such that the Defendants are subject to punitive damages.

WHEREFORE, Plaintiffs demand judgment against the Defendants in an amount in excess of this Court's jurisdictional limitations as allowed by statute plus costs, interest, attorney fees, and punitive damages.

Respectfully submitted:

KATHERMAN, BRIGGS & REENBERG, LLP

Dated: 5-15-14

BY: ______________________

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